STATEMENT OF

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BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA's CONSTRUCTION BUDGET REQUEST FOR FISCAL YEAR 2008

WASHINGTON, D.C. FEBRUARY 8, 2007

MR. CHAIRMAN AND MEMBERS OF THIS COMMITTEE:

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the U.S. (VFW), this nation's largest combat veterans' organization, I would like to thank you for the opportunity to testify today on the Fiscal Year 2008 budget for the Department of Veterans Affairs (VA).

The VA construction budget has, for the past few years, been dominated by the Capital Asset Realignment for Enhanced Services (CARES) process.

CARES is a system-wide, data-drive assessment of VA's capital infrastructure. It aimed to identify the needs of veterans to aid in the planning of future and realignment of current VA facilities to most efficiently meet those needs. It was not just a one-time evaluation but also the creation of a process and framework to continue to determine veterans' future requirements.

Throughout the entire CARES process, *The Independent Budget* veterans' service organizations (IBVSOs) were highly supportive, as long as VA emphasized the "ES"—enhanced services—portion of the acronym.

- 2001—CARES pilot study in Network 12 (Chicago, Illinois; Wisconsin; and Upper Michigan) completed.
- 2002—Phase II of CARES began in all other networks of VA individually, to be compiled in the Draft National CARES Plan.
- 2003—August: Draft National CARES Plan submitted to CARES Commission to review and gather public input.
- 2004—February: VA Secretary receives CARES Commission recommendations.

- 2004—May: VA Secretary announces his decision on CARES, but calls for additional "CARES Business Plan Studies" at 18 sites throughout the country.

These CARES Business Plan Studies are available on VA's CARES website, www.va.gov/cares. As of December 2006, only ten of these studies have been completed, despite VA's stated June 2006 deadline. The IBVSOs look forward to the final results so that implementation of these important plans can go forward.

The IBVSOs believe that all decisions on CARES should be consistent with the CARES Decision document and its established priorities, or with the findings of the CARES review commission that largely confirmed those priorities. Proposed changes or deviation from the plan should undergo the same rigorous data validation as the original projects.

CARES was intended to be an apolitical, data-driven process that looked out for the best interest of veterans throughout the entire system. We are certainly pleased that the Secretary and members of Congress are interested in the future of VA capital facilities, but we urge all involved to maintain consistency with the apolitical process that, as agreed to by all parties—stakeholders included—would provide the best way to determine future VA infrastructure needs to sufficiently care for all veterans. This was the hallmark of the CARES plan.

Throughout the CARES process, the IBVSOs were greatly concerned with the underfunding of the construction budget. Congress and the Administration did not devote many resources to VA's infrastructure, preferring to wait for the final results of CARES. In past *Independent Budgets* we warned against this, pointing out that there were a number of legitimate construction needs identified by the local manager of VA facilities. A number of facilities were authorized, including House passage of the "Veterans Hospital Emergency Repair Act," but funding was never appropriated, with the ongoing CARES review being used as the primary excuse.

At the time, the IBVSOs argued that a de facto moratorium on construction was unnecessary because of our conviction that a number of these projects needed to go forward and that they would be fully justified in any future plans produced through CARES. Despite this reasonable argument, funding never came, and VA lost progress on hundreds of millions of dollars that otherwise would have been invested to meet the system's critical infrastructure needs.

The IBVSOs continue to believe that this deferral of all major VA construction projects was poor policy. In the five-plus years the process took, construction and maintenance improvements lagged far beyond what the system truly needed. With CARES nearly complete, funding has not yet been proposed by the Administration nor approved by Congress to address the very large project backlog that has grown.

We note this year that both Veterans' Committees have considered legislation that would authorize resumption of VA major medical facility construction projects, but with the breakdown of the appropriations process, these projects died with the end of the 109th Congress.

In July 2004, VA Secretary Anthony Principi testified before the Health Subcommittee of the House Committee on Veterans' Affairs. In his testimony, he noted that CARES "reflects a need for additional investments of approximately $1 billion per year for the next five years to modernize VA's medical

infrastructure and enhance veterans' access to care." Since that statement, however, the amount actually appropriated by Congress for VA major medical facility construction has fallen far short of that goal; in fiscal year 2007, the administration recommended a paltry $399 million for major construction.

After that five-year de facto moratorium and without additional funding coming forth, VA facilities have an even greater need than they did at the start of the CARES process. Accordingly, we urge the administration and the Congress to live up to the Secretary's words by making a steady investment in VA's capital infrastructure to bring the system up to date with the needs of 21st century veterans.

For major construction, the IBVSOs recommend $1.602 billion in funding. This includes funding for the projects on VA's priority list, advanced planning, and for construction costs for a number of new national cemeteries in accordance with the NCA strategic plan.

Category	Funding (Dollars in th
CARES	1,400,000
Master Planning	20,000
Advanced Planning	45,000
Asbestos	5,000
Claims Analyses	3,000
Judgment Fund	2,000
Hazardous Waste	2,000
National Cemetery Administration	95,000
Staff Offices	5,000
Historic Preservation	25,000
TOTAL	$1,602,000

For minor construction, the IBVSOs recommend a total of $541 million, the bulk of which will go toward the more than 100 minor construction projects identified by VA in its five-year capital plan in fiscal year 2008.

Category	Funding (Dollars in thousands)
CARES/Non-CARES	450,000
National Cemetery Administration	40,000
Veterans Benefits Administration	35,000
Staff	6,000
Advanced Planning	10,000
TOTAL	541,000

Department of Veterans Affairs (VA) does not have adequate provisions to protect against deterioration and declining capital asset value.

The last decade of underfunded construction budgets has led to a reduction in the recapitalization of VA's facilities. Recapitalization is necessary to protect the value of VA's capital assets by renewing the physical infrastructure to ensure safe and fully functional facilities. Failure to adequately invest in the system will result in its deterioration, creating even greater costs down the road.

As in past years, we continue to cite the Final Report of the President's Task Force to Improve Health Care Delivery for our Nation's veterans (PTF). The PTF noted that in the period from 1996–2001, VA's recapitalization rate was 0.64 percent, which corresponds to an assumed building life of 155 years. When maintenance and restoration are factored into VA's major construction budget, VA annually invests less than 2 percent of plant replacement value in the system. The PTF observed that a minimum of 5 to 8 percent per year is necessary to maintain a healthy infrastructure and that failure to adequately fund could lead to unsafe, dysfunctional settings.

Congress and the Administration must ensure that there are adequate funds for major and minor construction so that VA can properly reinvest in its capital assets to protect their value and ensure that health care can be provided in safe and functional facilities long into the future.

The deterioration of many Department of Veterans Affairs (VA) properties requires increased spending on nonrecurring maintenance.

A Price Waterhouse study looked at VA facilities management and recommended that VA spend at least 2 to 4 percent of its plant replacement value on upkeep. Nonrecurring maintenance (NRM) consists of small projects that are essential to the proper maintenance and to the preservation of the lifespan of VA's facilities. Examples of these projects include maintenance to roofs, replacement of windows, and upgrades to the mechanical or electrical systems.

Each year, VA grades each medical center, creating a facility condition assessment (FCA). These FCAs give a letter grade to various systems at each facility and assign a cost estimate associated with repairs or replacement. The latest FCAs have identified $4.9 billion worth of necessary repairs in projects with a letter grade of "D" or "F." F's must be taken care of immediately, and D's are in need of serious repairs or represent pieces of equipment reaching the end of their usable life. Most of these projects would be reparable using NRM funds.

Another concern with NRM is with how it is allocated. NRM is under the Medical Care account and is distributed to various VISNs through the Veterans Equitable Resource Allocation (VERA) process. While this does move the money toward the areas with the highest demand for health care, it tends to move money away from facilities with the oldest capital structures, which generally need the most maintenance. It also could increase the tendency of some facilities to use maintenance money to address shortfalls in medical care funding.

VA should spend $1.6 billion on NRM to make up for the lack of proper funding in previous years and to keep VA on the right track with maintenance for the future.
VA must also resist the temptation to dip into NRM funding for health-care needs, as this could lead to far greater expenses down the road.

Veterans and staff continue to occupy buildings known to be at extremely high risk because of seismic deficiencies.

The Independent Budget veteran's service organizations (IBVSOs) continue to be concerned with the seismic safety of the Department of Veterans Affairs (VA) facilities. The July 2006 Seismic Design Requirements report noted the existence of 73 critical VA facilities that, based on FEMA definitions, are at a "moderately high" or greater risk of seismic incident. 24 of these have been deemed "very high" risk, the highest standard.

To address the safety of veterans and employees, VA includes seismic corrections in its annual list of projects to Congress. In conjunction with the Capital Asset Realignment for Enhanced Services process, progress is being made on eight of these facilities. More is needed, and, accordingly, funding will need to increase.

For efficiency, most seismic correction projects should also include patient care enhancements as part of their total scope. Seismic correction typically includes lengthy and widespread disruption to hospital operations; it would be prudent to make medical care improvements at the same time to minimize disruptions in the future. While this approach is the most practical for the delivery of health care and services as well as for cost-effectiveness, it also results in higher upfront project costs, which would require an increase in the construction budget.

Congress must appropriate adequate construction funding to correct these critical seismic deficiencies.

VA should schedule facility improvement projects concurrently with seismic corrections

Each Department of Veterans Affairs (VA) medical center needs to develop a detailed master plan.

This year's construction budget should include at least $20 million to fund architectural master plans. Without these plans, the Capital Asset Realignment for Enhanced Services (CARES) medical benefits will be jeopardized by hasty and short-sighted construction planning.

The Independent Budget veteran's service organizations believe that each VA medical center should develop a facility master plan to serve as a clear roadmap to where the facility is going in the future. It should be an inclusive document that includes multiple projects for the future in a cohesive strategy.

In many cases, VA plans construction in a reactive manner. Projects are funded first and then fitted onto the site. Each project is planned individually and not necessarily with respect to other ongoing projects or ones planned for the future. It is essential that each medical center has a plan that looks at the big picture to efficiently utilize space and funding. If all projects are not simultaneously planned, for example, the first project may be built in the best site for the second project. Master plans would prevent short-sighted construction that restricts, rather than expands, future options.

Every new project in the master plan is a step in achieving the long-range CARES objectives. These plans must be developed so that all future projects can be prioritized, coordinated and phased. They are essential to efficiently use resources, but also to minimize disruption to VA patients and employees. Medical priorities, for example, must be adjusted for construction sequencing. If infrastructure changes must precede new construction, master plans will identify this so that schedules and budgets can be adjusted. Careful phasing is essential to avoid disrupting the delivery of medical care, and the correct planning of such will ensure that cost estimates of this phased-construction approach will be more accurate.

There may be cases, too, where master planning will challenge the original CARES decisions, whether due to changing demand, unidentified need, or other cause. If CARES, for example, calls for the use of renovated space for a relocated program and a more comprehensive examination as part of a master plan later indicates that the site is impractical, different options should be considered. Master plans will help to correct and update invalid planning assumptions.

VA must be mindful that some CARES plans involve projects constructed at more than one medical center. Master plans, as a result, most coordinate the priorities of both medical centers. Construction of a new SCI facility, for example, might be a high priority for the "gaining" facility, but a lower priority for the "donor" facility. It may be best to fund and plan the two actions together, even though they are split between two different facilities.

Another essential role of master planning is its use to account for three critical programs that VA left out of the initial CARES process: long-term care, severe mental illness, and domiciliary care. Because these were omitted, there is a strong need for a comprehensive plan, and a full facility master plan will help serve as a blueprint for each facility's needs in these essential areas.

VA must ensure that each medical center develops and continues to work on long-range master plans to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruptions to patient care.

Congress must appropriate $20 million to allow each VA medical facility to develop architectural master plans to serve as roadmaps for the future.

Each facility master plan should address long-term care, including plans for those with severe mental illness, and domiciliary care programs, which were omitted from the CARES process.

VA must develop a format for these master plans so that there is standardization throughout the system, even though planning work will be performed by local contractors in each Veterans Integrated Service Network.

The Department of Veterans Affairs (VA) must develop a strategic plan for the infrastructure needs of these important programs.

The initial Capital Asset Realignment for Enhanced Services (CARES) plan did not take long-term care or the mental health considerations of veterans into account when making recommendations. We were pleased that the CARES Review Commission recognized the need for proper accounting of these critical components of care in VA's future infrastructure planning. However, we continue to await VA's development of a long-term care strategic plan to meet the needs of aging veterans. The commission recommended that VA "develop a strategic plan for long-term care that includes policies and strategies for the delivery of care in domiciliary, residential treatment facilities and nursing homes, and for older seriously mentally ill veterans."
Moreover, the commission recommended that the plan include strategies for maximizing the use of state veterans' homes, locating domiciliary units as close to patient populations as feasible and identifying freestanding nursing homes as an acceptable care model. In absence of that plan, VA will be unable to determine its future capital investment strategy for long-term care.

VA must take a proactive approach to ensure that the infrastructure and support networks needed by veterans will be there for them in the future.

We also concur with the CARES Commission's recommendations that VA take action to ensure consistent availability of mental health services across the system to include mental health care at community-based clinics along with the appropriate infrastructure to match demand for these specialized services. This is important in light of the growing demand for these types of services, especially among those returning from overseas in the wars in Iraq and Afghanistan.

VA must develop a long-term care strategic plan to account for the needs of aging veterans now and into the future. This should include care options for older veterans with serious mental illnesses.

VA must also develop plans to provide for the infrastructure needs associated with mental health care services, especially with the unprecedented current need for these services, and the likely tremendous long-term need of our returning service members.

The Department of Veterans Affairs (VA) must not use empty space inappropriately.

Studies have suggested that the VA medical system has extensive amounts of empty space that can be reused for medical services. It has also been suggested that unused space at one medical center may help address a deficiency that exists at another location. Although the space inventories are accurate, the assumption regarding the feasibility of using this space is not.

Medical facility planning is complex. It requires intricate design relationships for function, but also because of the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. Unoccupied rooms on the eighth floor, for example, cannot be used to offset a deficiency of space in the second floor surgery ward. Medical space has a very critical need for inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care.

When a department expands or moves, these demands create a domino effect of everything around it, and these secondary impacts greatly increase construction expense and they can disrupt patient care.

Some features of a medical facility are permanent. Floor-to-floor heights, column spacing, light, and structural floor loading cannot be altered. Different aspects of medical care have different requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the needs of different column spacing and perimeter configuration. Patient wards require access to natural light and column grids that are compatible with room-style layouts. Labs should have long structural bays and function best without windows. When renovating empty space, if the area is not suited to its planned purpose, it will create unnecessary expenses and be much less efficient.

Renovating old space rather than constructing new space creates only a marginal cost savings. Renovations of a specific space typically cost 85 percent of what a similar, new space would. When you factor in the aforementioned domino or secondary costs, the renovation can end up costing more and produce a less satisfactory result. Renovations are sometimes appropriate to achieve those critical functional adjacencies, but it is rarely economical.

Many older VA medical centers that were rapidly built in the 1940s and 1950s to treat a growing veteran population are simply unable to be renovated for more modern needs. Most of these Bradley-style buildings were designed before the widespread use of air conditioning and the floor-to-floor heights are very low. Accordingly, it's impossible to retrofit them for modern mechanical systems. They also have long, narrow wings radiating from a small central core, which is an inefficient way of laying out rooms for modern use. This central core, too, has only a few small elevator shafts, complicating the vertical distribution of modern services.

Another important problem with this unused space is its location. Much of it is not located in a prime location; otherwise it would have been previously renovated or demolished for new construction. This space is typically located in outlying buildings or on upper floor levels and is unsuitable for modern use.

VA should develop a plan for addressing its excess space in non-historic properties that are not suitable for medical or support functions due to their permanent characteristics or locations.

The Department of Veterans Affairs (VA) must continue to develop and revise facility design guides for spinal cord injury/ spinal cord disorders.

With the largest health-care system in the U.S., VA has an advantage in its ability do develop, evaluate, and refine the design and operation of its many facilities. Every new clinic's design can benefit from lessons learned from the construction and operation of previous clinics. VA also has the unique opportunity to learn from medical staff, engineers, and from its users—veterans and their families—as to what their needs are, allowing them to generate improvements to future designs.

As part of this, VA provides design guides for certain types of facilities that provide care to veterans. These guides are rough tools used by the designer, clinician, staff, and management during the design process. These design guides, which are viewable on the Facilities Management webpage, cover a variety of types of care.

These design guides, due to modernization of equipment and lessons learned at other facilities, should be revised regularly. Some of the design guides have not been updated in over a decade, despite the massive transition of the VA health-care system from an inpatient-based system. *The Independent Budget* veterans' service organizations (IBVSOs) understand that VA intends to regularly update these guides, and we would urge that increased funding be allocated to the Advanced Planning Fund to revise and update these essential guides.

As in past years, the IBVSOs would note the need for guides for long-term care at spinal cord injury/dysfunction (SCI/D) centers. It is important that these guides be separate from the guides that call for acute care as the needs of the two are dramatically different.

These facilities must be less institutional in their character with a more homelike environment. Rooms and communal space should be designed to accommodate patients who will be living at these facilities for a long time. They must include simple ideas that would improve the daily life of these patients. Corridor length should be limited. They should include wide areas with windows to create tranquil places or areas to gather. Centers should have courtyard areas where the climate is temperate and indoor solariums where it is not. We believe that a complete guideline for these facilities would also include a discussion of design philosophies that emphasize the quality of life of these patients, and not

just the specific criteria for each space. Because the type of care these patients need is unique, it is essential that this type of design guidance is available to contracted architects.

VA must revise and update their design guides on a regular basis.

VA should develop a long-term care design guide for SCI/D centers to accommodate the special needs of these unique patients.

The Department of Veterans Affairs' extensive inventory of historic structures must be protected and preserved.

VA has an extensive inventory of historic structures, which highlight America's long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, and who helped to develop this great nation. Of the approximately 2,000 historic structures, many are neglected and deteriorate year after year because of a lack of funding. These structures should be stabilized, protected, and preserved because of their importance.

Most of these facilities are not suitable for modern patient care, and, as a result, a preservation strategy was not included in the Capital Asset Realignment for Enhanced Services process. As a first step in addressing its responsibility to preserve and protect these buildings, VA must develop a comprehensive program for these historic properties.

VA must make an inventory of these properties, classifying their physical condition and their potential for adaptive reuse. Medical centers, local governments, nonprofit organizations or private sector businesses could potentially find a use for these important structures that would preserve them into the future.

The Independent Budget veterans' service organizations recommend that VA establish partnerships with other federal departments, such as the Department of the Interior, and with private organizations, such as the National Trust for Historic Preservation. Their expertise would be helpful in creating this new program.

As part of its adaptive reuse program, VA must ensure that facilities that are leased or sold are maintained properly for preservation's sake. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds. We would point to the partnership between the Department of the Army and the National Trust for Historic Preservation as an example of how VA could successfully manage its historic properties.

P.L. 108-422, the Veterans Health Programs Improvement Act, authorized historic preservation as one of the uses of a new capital assets fund that receives funding from the sale or lease of VA property. We applaud its passage, and encourage its use.
VA must begin a comprehensive program to preserve and protect its inventory of historic properties.

We thank you for allowing us to testify today, and we would be happy to answer any questions that you or the committee may have.